

# ***Health Policy Newsletter***

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**Volume 17 Number 3**

**September, 2004**

**Article 12**

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## **The Personal Care Partnership Program**

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**Suggested Citation:**

Minnick C, Campbell J, Graub PB, Ratajczak E, Irvine CA. The personal care partnership program. *Health Policy Newsletter* 2004; 17(3): Article 12. Retrieved [date] from <http://jdc.jefferson.edu/hpn/vol17/iss3/12>.

## The Personal Care Partnership Program

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Providing affordable and quality long-term care for the frail elderly continues to be challenging both nationally and in Pennsylvania. One type of housing in the long-term care continuum is the personal care home (PCH), which provides room, board, and assistance to those in need. Many low-income, frail elderly live in PCHs, and due to increased frailty may already require a nursing home level of care. While resources such as the Home and Community Based Waiver Programs are available to those living in their own home, those in PCHs are not able to access these services due to regulatory constraints. Therefore, once their medical and functional needs become more than the staff at the PCH can manage, they are often forced into nursing home placement.

Currently, over 53,000 people live in PCHs in Pennsylvania. Philadelphia has one of the state's fastest-growing, largest, and most vulnerable populations of low-income elderly residing in 151 PCHs, with over 5,800 beds, the majority of which are SSI-funded.<sup>1</sup>

The Personal Care Partnership Program (PCPP) is a multiagency demonstration project funded by The Robert Wood Johnson Foundation Building Health Systems Program, The Pew Charitable Trusts, the Administration on Aging, and the Albert Einstein Society. Albert Einstein Healthcare Network and Philadelphia Corporation for Aging serve as the lead agencies coordinating the initiative.

PCPP was designed to establish a coordinated system of healthcare for elderly residents living in PCHs who are Nursing Facility Clinically Eligible (NFCE) and financially eligible for Medical Assistance-reimbursed nursing home care, but who have chosen to remain living in the community in their PCH. After an 18-month planning process involving the project team, the Pennsylvania Department of Public Welfare, and the Pennsylvania Department of Aging, the program was phased into 18 PCHs in Philadelphia. PCPP serves residents over the age of 60 who meet the eligibility criteria for the Pennsylvania Department of Aging Home and Community Based Medicare Waiver Program. The goals of PCPP are to 1) establish positive health outcomes for NFCE residents of PCHs; 2) demonstrate cost savings for residents receiving waiver services in PCHs; 3) avoid or delay unnecessary transitioning to a higher locus of care (either a nursing home or a hospital); and 4) establish the PCH as a viable and vital healthcare delivery site within the continuum of care.

The PCPP Model of Care consists of an interdisciplinary team comprised of a nurse practitioner from a local hospital and a care manager from the Area Agency on Aging system who work closely with each resident's community physician. After an initial screening, individual residents undergo a full Medicare Waiver Program assessment, consent to participate in the demonstration project, and have a care plan developed and implemented in conjunction with the services already provided by the PCH. The interdisciplinary team monitors the services to support the residents in at least maintaining their health status.

An evaluation plan was developed and data were collected every three months from June 2000 through July 2002 with the study group (n=121) and the comparison group (n=51). Results suggested that the participants benefited from the intervention of the nurse practitioners through avoided hospitalization and nursing home placement. The average cost of providing service to PCPP residents is less than placement in a nursing home at Medical Assistance/Medicaid reimbursement rates. PCPP placement was shown to delay

entry into nursing homes for eleven residents in the study group, saving an estimated \$232,075 in placement costs.

The PCPP continues to operate in Philadelphia, pending approval of the final evaluation report by the State Demonstration Advisory Committee and further recommendation of state policy-making agencies.

## **References**

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